EXHIBIT A

91626

Printed on: 3/24/2014

JAIL INCIDENT REPORT

STEARNS COUNTY SHERIFFS OFFICE

Incident Number: SuggestedNumber

Incident Description: FIGHTING

Incident Date: 3/24/2014 11:55:00AM

Reporting Officer: STOWELL CRAIG R

Inmates Involved:

09J0215 : OLTZ, KYLE LESTER

10J2007 : TAYLOR, ZACHARY TYLER

Narratives:

Title: FIGHTING

Entered By: CRAIG R STOWELL
Date Entered: 3/24/2014 12:22:0

On this date at approximately 11:55 hrs I heard a radio call for assistance to the West housing unit.
While responding to the area I ordered multiple inmate in the hallway to sit along the wall. Upon arrival at West housing I observed Officer Proshek with inmate Oltz, Kyle cuffed behind his back and being searched.
Upon my entry into West, Oltz was stood up and moved out of the area. At this time I was informed of another party injured in the G unit. Upon my and several other officers entering the unit I observed inmate Taylor, Zachary lying on his left side crying and yelling his arm hurt.
(Note arm was broken from outside LE contact.) I assumed control of the head and Sgt Knoll performed a secondary survey and noted no additional injuries. Taylor stated his head and neck hurt plus his arm. Per on scene medical RN we placed
a cervical collar on Taylor and rolled him onto a backboard for evaluation. RN Elaine completed full exam of Taylor and cleared him to be without cervical collar and had him stand and move to his cell and lay down. Ice was given for his arm.
Medical staff will follow up treatment with Dr.
West housing officer briefed of situation.

Craig R Stowell

Printed on: 3/24/2014

JAIL INCIDENT REPORT

STEARNS COUNTY SHERIFFS OFFICE

Incident Number: SuggestedNumber
Incident Description: ASSAULT
Incident Date: 3/24/2014 11:45:00
Reporting Officer: REVERING ANN M

Inmates Involved:

09J0215 : OLTZ, KYLE LESTER

10J2007 : TAYLOR, ZACHARY TYLER

Narratives:

Title:

Entered By: ANN M REVERING
Date Entered: 3/24/2014 14:15:3

On 03/24/14 I Officer Revering was assigned to west housing on the day shift At approximately 1145 I was removing the laundry cart from the F unit via the 2FGB door when the facial expression on the inmates in F-unit told me that was a problem behind me. When I turned around I heard a loud thud and could only see the arms of somebody throwing punches (identified as Kyle Oltz#90613). I called for assistance in West housing. As I got closer to the window of the sally port I saw another inmate on the floor under the one who was throwing punches (identified as Zachary Taylor #91626). Officer Proshek was the first to arrive he secured inmate Oltz on the floor and cuffed him behind his back. Myself and Sgt Gacke ordered inmate Taylor into the G-unit I then took Taylor by the arm and directed him through the 202c door into the unit. Once Taylor was in the unit I went back into the sally port and Sgt Gacke stayed with Taylor in the G unit. Once Oltz was escorted out of the sally port I returned to the G unit By this time other officers were tending to the needs of inmate Taylor who was on the floor in the G-unit. Officer Folta secured all the units and I resumed normal housing unit duties as Medical and other staff were tending to inmate Taylor. End of Report

A.Revering

Printed on: 3/24/2014

JAIL INCIDENT REPORT

STEARNS COUNTY SHERIFFS OFFICE

Incident Number: SuggestedNumber

Incident Description: ASSAULT

Incident Date: 3/24/2014 11:45:00AM

Reporting Officer: PROSHEK ADAM S

Inmates Involved:

10J2007 : TAYLOR, ZACHARY TYLER

09J0215 : OLTZ, KYLE LESTER

Narratives:

Title: INMATE FIGHT

Entered By: ADAM S PROSHEK
Date Entered: 3/24/2014 3:44:2

ON TODAY'S DATE, AT APPROXIMATELY 1145 HRS., OFC. REVERING CALLED FOR ASSISTANCE IN WEST HOUSING. I RESPONDED IMMEDIATELY FROM THE BOOKING INTAKE AREA. AS I CAME AROUND THE CORNER, IN THE SOUTH HALLWAY, BY WEST HOUSING OUTDOOR RECREATION, I SAW A FEW INMATES OUTSIDE THE WEST HOUSING ENTRANCE DOOR (202A). THE DOOR WAS WIDE OPEN.

I ENTERED THE WEST HOUSING SALLYPORT AND SAW INMATE OLTZ, KYLE LINK # 90613 COMING TOWARDS ME. INMATE TAYLOR, ZACHERY LINK # 91626 WAS LYING ON THE FLOOR NEXT TO THE WALL CLOSEST TO THE OFFICERS DESK. I ORDERED OLTZ TO GET ON THE FLOOR. OLTZ COMPLIED. I THEN KNELT DOWN TO HANDCUFF OLTZ, WHEN TAYLOR GOT UP OFF THE FLOOR AND STARTED TO COME TOWARDS OLTZ AND I. TAYLOR WAS EXTREMELY ANGRY AND WAS LOOKING AT OLTZ AS HE WAS MOVING TOWARDS OLTZ AND I. TAYLOR YELLED " YOU FUCKING BICTH" AT OLTZ. I THEN STOOD UP AND ORDERED TAYLOR TO BACK UP AND GET ON THE FLOOR.

OFC. REVERING THEN TOOK CONTROL OF TAYLOR AND ESCORTED HIM THROUGH THE 202C DOOR INTO THE G-UNIT OF WEST HOUSING. I THEN PLACED HANCUFFS ON OLTZ. I CHECKED THE HANDCUFFS FOR PROPER FIT AND DOUBLE LOCKED THEM FOR EVERYONE'S PROTECTION. I THEN PAT SEARCHED OLTZ. OLTZ WAS THEN BROUGHT TO HIS FEET AND ESCORTED INTO THE HALLWAY OUTSIDE OF WEST HOUSING. I ASKED SGT. SALZER WHERE OLTZ SHOULD BE TAKEN. SALZER ADVISED THAT THE SEGREGATION UNIT WAS FULL, SO OLTZ SHOULD BE TAKEN TO BOOKING AND PLACED IN A CELL THERE.OFC.'S BREZINKA AND FARROW THEN ESCORTED OLTZ TO BOOKING.

SGT. GACKE THEN ASKED ME TO GO TO MEDICAL TO COPY TAYLOR'S MEDICATION INFO, IN CASE HE WAS TO BE TRANSPORTED TO THE HOSPITAL. I LEFT WEST HOUSING AT THAT POINT AND HAD NO FURTHER CONTACT WITH EITHER INMATE.

PROSHEK #2779

COI PROSHEK

SUPERVISOR

EXHIBIT B

Background Information

October 2008

Delegation of Medical Practice to Physician Assistants

Registration and education

Applicants for physician assistant registration must be certified by the National Commission on Certification of Physician Assistants (M.S. 147A.02). The NCCPA administers a certification exam to graduates of programs accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Educational institutions offering physician assistant programs must offer a baccalaureate or higher degree. Minnesota's only physician assistant training program is at Augsburg College. The three-year Augsburg program requires a baccalaureate degree for entry and leads to a Master of Science in Physician Assistant Studies and a PA certificate.

Physician supervision

Physician assistants may practice medicine only with physician supervision and may perform only those duties and responsibilities delegated to the physician assistant (M.S. 147A.09). The law defines "supervision" to mean "overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant." Supervision can occur by personal contact or through telecommunications (M.S. 147A.01, Subd. 24). A physician may not supervise more than two full-time equivalent physician assistants simultaneously (Subd. 23).

Scope of practice

Patient services of physician assistants are limited to services that are:

- Within the training and experience of the physician assistant,
- Customary to the practice area of the supervising physician,
- Delegated by the supervising physician, and
- Within the parameters of the laws, rules, and standards of the facilities in which the physician assistant practices (M.S. 147A.09, Subd. 1).

Patient services may include, but are not limited to:

- Taking patient histories and developing medical status reports,
- Physical examinations,
- Interpretation and evaluation of patient data,
- Ordering or performance of diagnostic procedures (including radiography),
- Ordering or performance of therapeutic procedures,
- Instructions for patient care, disease prevention and health promotion,
- Assisting physician supervision of patient care,
- Creating and maintaining patient records,
- Transmitting and executing orders at the direction of the supervising physician,
- Prescribing, administering and dispending legend drugs and medical devices (only this function has been delegated by the supervising physician),
- Administering legend drugs and medical devices following prospective review by and upon direction of the supervising physician,
- Initiating evaluation and treatment in emergency situations, and
- Certifying physical disability for parking permits.

(Subd. 2)

Delegation of Medical Practice to Physician Assistants

Practice Agreements

A physician assistant must practice within terms of a written agreement between the physician assistant and a supervising physician that defines the scope and nature of supervision. A separate agreement is required for each place of employment (M.S. 147A.20(b)). The agreement must describe:

- Practice setting,
- Practice type or specialty,
- Categories of delegated duties,
- Type, amount and frequency of supervision, and
- Process and schedule for review of any delegated prescribing, dispensing and administration of drugs and medical devices (including an internal protocol and delegation form) (M.S. 147A.20(a).

Prescribing

The supervising physician may delegate authority to prescribe, dispense and administer legend drugs, medical devices and controlled substances. The authority to dispense extends only to drugs described in the written agreement. Delegation must be "appropriate to the physician assistant's practice and within the scope of the physician assistant's training" as evidenced by certifications from the National Commission on Certification of Physician Assistants (M.S. 147A.18, Subd. 1).

The Board of Medical Practice is authorized develop rules for:

- a system for identifying physician assistants eligible to prescribe, dispense or administer legend drugs, medical devices or controlled substances,
- a method for determining the categories of drugs and devices that each physician assistant is allowed to prescribe, dispense or administer, and
- a system of transmitting to pharmacies a list of physicians assistants eligible to prescribe legend and controlled drugs

(M.S. 147A.18, Subd. 2).

EXHIBIT C

ST. CLOUD ORTHOPEDIC ASSOCIATES, LTD.
1901 Connecticut Avenue South Sartell, Minnesota 56377
(320) 259-4100

Zachary T Taylor DOB:

05/12/2014

LEFT WRIST CONDITION
Requested by: None.

CHIEF COMPLAINT: Left wrist injury.

HISTORY: Taylor is a 45-year-old left-hand dominant male who presents today for evaluation of his left wrist fracture. He presents today with prison guards as he is currently incarcerated. He sustained this injury six weeks ago on 03/24/2014. He sustained a fracture during his rest. He was originally seen in the emergency department and x-rays confirmed a fracture. He is placed in a splint and sent back to county jail. He was then eventually incarcerated in prison. Followup x-rays demonstrated a subacute fracture with signs of healing and malalignment and malunion. He continues to have pain on a daily basis. He has almost no motion of his wrist. He states he has numbness and tingling in all of his fingers, worse in the middle, ring, and small fingers. He had no previous fractures or injuries that he can recall.

ALLERGIES/MEDICATIONS/PAST MEDICAL/PAST SURGICAL/SOCIAL/FAMILY HISTORY/REVIEW OF SYSTEMS: Found within the patient's health history questionnaire and our electronic medical records dated 05/12/2014. In brief, he has no medical problems. He does have an allergy to succinylcholine.

PHYSICAL EXAM: Vitals: Blood pressure 144/100, height 6 feet tall, and weight 170 pounds. He is alert and oriented x3, in no acute distress. He is well-nourished and well-hydrated. He is pleasant and cooperative. Head is normocephalic and atraumatic. Pupils are equal, round, and reactive. Heart regular rate and rhythm. Lungs were clear to auscultation. Abdomen was soft and nontender. Musculoskeletal examination of the left upper extremity reveals his skin to be intact. There is minimal swelling and some deformity noted of the wrist region with the carpals translated volarly somewhat in relation to the forearm. He has almost no range of motion of his wrist, maybe a 20-degree arc of motion. He does not tolerate much supination or pronation. He is tender to palpation, both volarly and dorsally. His sensation is intact to light touch throughout all of his fingers. He is able to wiggle his fingers and his thumb. There are no open sores or lesions noted of his skin. He is currently in a short-arm splint.

IMAGING: Two views of the left wrist obtained at an outside facility

ST. CLOUD ORTHOPEDIC ASSOCIATES, LTD.
1901 Connecticut Avenue South Sartell, Minnesota 56377
(320) 259-4100

Zachary T Taylor DOB:

05/12/2014
(Continued)

were reviewed. There is a subacute impacted transverse fracture through the distal radius with volar angulation. The volar cortex is kicked out volarly and there is some impaction of the articular surface corresponding with an intra-articular fracture. The carpals are translated volarly as well but the wrist is reduced.

IMPRESSION: Closed left intra-articular distal radius subacute fracture with malunion.

PLAN: I discussed the above findings with Taylor at length and reviewed treatment options, both operative and nonoperative management. Given his left hand dominance and the extent of his injury and malunion, I have recommended **open reduction and internal fixation of his distal radius fracture.** The risks, benefits, complications, and alternatives were discussed. He voiced understanding and he wishes to proceed. We will get this scheduled for him at his earliest convenience. We placed him back into a splint. We will have him icing and elevating in the meantime. All questions were answered.

Timothy G. Hiesterman, D.O.

TGH/om/sb

Patient Name Zachary Taylor DOB

Dr Hiestermann Date of Service 5-12-14 Chart #

CHIEF COMPLAINT: (L) dist Radius fx (L) Dom

REFERRING M.D. Ø

ONSET: WHEN: 6wks ago

HOW: Tackled, fx'd arm

- painful
- NIT in all fingers worse in 3,4,5
- Ø previous fx
- ↓ strength

PREVIOUS TREATMENT: Splint

TPR:
B.P 144/100
HT 6'
WT 170
AGE: 45
EMPLOYMENT Inmate
INT: AZ

PREVIOUS X-RAYS:	DATE TAKEN	VIEWS	WHERE TAKEN
NONE	5-6-14	(L) wrist	SCOA PPX

EXAMINATION:	ROM	STABILITY	STRENGTH	INSPECTION/PALPATION

#031-A 6/08

ST. CLOUD ORTHOPEDIC ASSOCIATES, LTD.
1901 Connecticut Avenue South Sartell, Minnesota 56377
(320) 259-4100

Zachary T Taylor DOB:

05/28/2014

SUBJECTIVE: The patient is a very pleasant 45-year-old male that underwent:

1. Takedown of a left distal radius malunion with a radial osteotomy.
2. Open reduction and internal fixation of a three-part intra-articular distal radius fracture.
3. Autograft bone grafting to the left distal radius.
4. Manipulation of the left wrist under anesthesia that were all performed on 05/14/2014.

The patient presents to the office with a pleasant affect and manner today. The patient states that he had swelling in his left arm shortly after his surgery. The patient went to the emergency room recently for a workup for cellulitis that returned negative. The patient states shortly after he returned back to the penitentiary where he resides shortly after his surgery that his pain medication were discontinued and he has been living with pain over the last two weeks. The pain has not been managed up until this point and the patient has been wearing his splint the whole time. The patient states that he does not have any further complaints beyond the fact that his pain has not been managed at this time by the facility that he resides in.

OBJECTIVE: Zachary Taylor was examined today by Dr. Hiesterman. Examination of the skin site reveals the surgical incision to be intact without any breaks in the integument. Skin tone is good without any peripheral edema. The incision is intact, clean, and dry without erythema or drainage. The patient still has Steri-Strips that were applied to the skin after his operative procedure and they are still on the incision site. Range of motion was not ascertained upon physical exam today. Slight tenderness was elicited to palpation during physical exam. No focal neural deficits were appreciated upon physical exam. Capillary refill is brisk and all pulses were appreciated. Distal extremities from the fracture site are soft, supple, and well perfused, free of edema or effusion.

IMAGING: Two-view x-rays were taken today of the left distal radius. Those x-rays were taken here in the clinic today. The x-rays were reviewed by Dr. Hiesterman and show the hardware to be intact. There are no signs of loosening or failure. The fracture appears to be anatomically reduced.

ST. CLOUD ORTHOPEDIC ASSOCIATES, LTD.
1901 Connecticut Avenue South Sartell, Minnesota 56377
(320) 259-4100

Zachary T Taylor DOB:

05/28/2014
(Continued)

ASSESSMENT: Approximately two weeks status post from:

1. Takedown of left distal radius malunion with radial osteotomy.
2. Open reduction and internal fixation of three-part intra-articular distal radius fracture.
3. Autograft bone grafting to left distal radius.
4. Manipulation of the left wrist under anesthesia.

PLAN: Dr. Hiesterman's recommendation is to have a followup scheduled with this patient in four weeks. The x-ray views for the next visit are going to be two views of the left distal radius. The patient was taken out of his splint and was fitted and supplied here in the clinic today with a left-handed D-ring splint. The patient was also educated to continue with a nonweightbearing status. No pushing, pulling, opening of doors, or lifting anything heavier than a pencil until his next appointment. The patient was given another prescription for Norco to help with breakthrough pain that he is not receiving in the prison. Occupational therapy order was given to the patient for active and passive range of motion, but no strengthening exercises at this time. In addition, all questions and concerns were answered today to the patient's satisfaction. The patient has been instructed to call immediately if he has any further questions or concerns in the interim.

This dictation represents the care plan for Zachary Taylor.

The patient was seen, evaluated, and assessed today by Dr. Hiesterman. The above dictation represents Dr. Hiesterman's care plan.

Brian Lee PAC

Timothy G. Hiesterman, D.O.

BL/cw/rb/

CENTRACARE
St. Cloud Hospital

Document: 11166451

PREOPERATIVE DIAGNOSIS: Closed three-part intraarticular left distal radius fracture with malunion.

POSTOPERATIVE DIAGNOSIS: Closed three-part intraarticular left distal radius fracture with malunion.

OPERATIVE PROCEDURE:
1. TAKEDOWN OF LEFT DISTAL RADIUS MALUNION WITH RADIAL OSTEOTOMY.
2. OPEN REDUCTION/INTERNAL FIXATION, THREE-PART INTRAARTICULAR DISTAL RADIUS FRACTURE.
3. AUTOGRAFT BONE GRAFTING TO LEFT DISTAL RADIUS.
4. MANIPULATION OF LEFT WRIST UNDER ANESTHESIA.

SURGEON: Timothy Hiesterman, DO

ASSISTANT(S): Brian Lee, PA-C

ANESTHESIA: General.

IMPLANTS: Synthes variable angle volar locking plate.

FINDINGS: The patient had a displaced three-part intraarticular distal radius fracture that occurred over 6 weeks ago. His injury occurred during his arrest. He eventually was incarcerated and presented 6 weeks out after his surgery with left wrist deformity, stiffness and a three-part intraarticular distal radius fracture mal-reduced and now healed in this position. In surgery his distal radius was completely healed with mature callus. Takedown of the osteotomy took an extended period of time. It required an osteotomy of the distal radius, freeing up each individual intraarticular fragment. Following our reduction, there was a significant bone void as his radius was brought out to length. We utilized some of the bone graft from the callus previously removed for autograft bone grafting of this site. In addition, we augmented this with OrthoBlend small defect allograft bone graft. At the conclusion of the case, once all hardware was placed, he had relatively good wrist extension to approximately 80 degrees, but had almost no wrist flexion. We did perform a manipulation of his wrist under anesthesia, gently stretching out his wrist both with flexion and extension, and at the conclusion we were able to get approximately 80 degrees of wrist flexion.

22-MODIFIER: This patient's case qualifies for a 22-Modifier due to the complexity of the fracture, both in the essence that it was a complex three-part intraarticular fracture, but also

was now fully healed in a malunited position. His three-part intraarticular distal radius fracture had significant impaction and displacement of the articular fragments and displacement of his fracture. These fragments were all healed and each one needed to be taken down with a radial osteotomy of each fracture fragment. These factors made his surgery extremely technically difficult. This required additional time for preoperative planning, exposure of the fracture, reduction of the fracture and application of the hardware, the level of complexity of the fracture and technical difficulty of the case is in the top 1% of cases that I see as an Orthopedic Traumatologist Specialist. For these reasons, I feel he qualifies for a 22-Modifier as this case was unusually difficult, time consuming and resource consuming.

PROCEDURE: The patient was identified in the preoperative holding area, both verbally and by name badge. The correct operative site was indicated and marked. The patient was transferred back in the operative suite and was placed supine. Anesthesia was administered per the Anesthesia Department. Once asleep, the patient was positioned supine. All bony prominences were well padded and protected. A tourniquet was placed around the left upper arm. This was later inflated to 250 mmHg. Following exsanguination with an Esmarch, the left upper extremity was prepped and draped in a normal sterile fashion.

A standard volar FCR approach was fashioned over the distal radius. The skin and subcutaneous tissues were sharply incised. Hemostasis was achieved via electrocautery. Dissection was carried down onto the flexor carpi radialis tendon. This was mobilized ulnarly. Sharp dissection was carried down through the tendon sheath floor. The FPL muscle belly was identified and retracted ulnarly. The pronator quadratus was identified. The radial artery and nerve were retracted radially. The pronator was then elevated sharply along the radial and distal borders, exposing the distal radius. There was noted to be significant malunion of the fracture with it displaced volarly and impacted. There is an abundance of callus around the malunion, and the fracture was completely healed with no evidence of motion. At this point, we then proceeded with a meticulous takedown of the nonunion. This was performed with rongeurs, osteotomes and Freer elevators, exposing the callus and preserving the bony cortex. Approximately one-half hour of time was spent alone just on taking down the malunion. This was quite time consuming and difficult. The fracture was a three-part intraarticular distal radius fracture and each fracture fragment had to be individually exposed and osteotomized to free it up from the surrounding bone in order to elevate this into a reduced position. Numerous osteotomies of the distal radius were performed to accomplish this. The articular surface was then elevated and we utilized two 0.054 K-wires from volar to dorsal just beneath the subchondral bone of our articular surface. The articular surface was elevated, held and our K-wires were passed. After doing so, the wrist was brought through a range of motion and there was no grinding or crepitus felt.

At this point, we then proceeded with reduction of our distal fragment. This required traction and manipulation to restore the length, alignment and rotation. We then used two 0.062 K-

wires obliquely through the radial styloid to maintain this alignment. In doing so, there was a bone void created in the metaphysial region of the distal radius as there was significant impaction of the fracture. This was approximately between a 5-10 cc defect. We did meticulously collect all autograft bone graft from our osteotomy sites and the callus around our fracture. This was all collected and used as an autograft bone grafting of the distal radius. Additionally we did need an OrthoBlend small defect allograft bone graft to augment this for filling our defect. Prior to bone grating, the wound was copiously irrigated with normal saline solution. We first packed in our autograft bone grafting into our defect and after we used all of this then we utilized our allograft bone graft to finalize the filling of our bone void.

Next, we selected our plate. This was a Synthes variable angle volar locking plate. This was positioned on the volar cortex and secured with K-wires. Our plate position was checked radiographically and was appropriate. We then proceeded to apply a 2.7 mm cortex screw in the oblong hole of the plate. Minor adjustments were made in the plate position. We then proceeded with applying our distal interlocking screws. All of our screws were placed in subchondral fashion and were confirmed to be extraarticular and of appropriate length. All distal interlocking screws were placed. We finalized our construct placing two additional 2.4 mm locking screws in the shaft. Final radiographs confirmed that our reduction was near anatomic and our plate and screw construct were in appropriate position on all views. Our bone void also appeared to be nicely grafted.

Next, we again copiously irrigated out the wound and proceeded to manipulate the wrist. The wrist had fairly good extension up to 80 degrees, but had almost no wrist flexion due to his prolonged immobilization and deformity. We then proceeded with a manipulation of the wrist under anesthesia. This was done slowly and we were able to manipulate the wrist, getting approximately 80 degrees of wrist flexion. His supination and pronation was checked and was full, and there was no instability. At this time, we then proceeded to close our pronator quadratus with 2-0 Vicryl, our subcutaneous tissues were closed with 2-0 and 3-0 Vicryl, and our skin was reapproximated with 4-0 Monocryl in subcuticular fashion. The tourniquet was deflated prior to closure and hemostasis was achieved via electrocautery. Our incision was reinforced with Benzoin and Steri-Strips, and a sterile dressing was applied consisting of 4 x 4's, Sof-Rol and a volar splint secured with an Ace bandage.

ESTIMATED BLOOD LOSS: 5 mL.

COMPLICATIONS: None.

SPECIMENS: None.

DISPOSITION: The patient was transferred out of the operative suite in stable condition. He will be nonweightbearing to his left upper extremity. We will maintain him in the splint and I will

see him back in the office in 2 weeks, at which time we will repeat radiographs, 2 views of the left wrist out of his splint. We will then get him into a removable wrist splint and initiate occupational therapy for range of motion exercises. The prison will call or notify me if there are any questions or concerns in the interim.

Timothy G. Hiesterman, DO
bab
D: 05/14/2014 10:34 A
T: 05/14/2014 12:00 P

ED:
ET:
Doc #: 11166451
cc: Timothy G. Hiesterman, DO

REPORT OF SURGERY
HEALTH INFORMATION DEPARTMENT
ST. CLOUD HOSPITAL
1406 6 AVENUE NORTH
ST. CLOUD, MN 56303 (320) 255-5624
CONFIDENTIAL COPY FORTimothy G. Hiesterman, DO

NAME: Taylor, Zachary T
ROOM: SCHPCSC 28 MR#:
SURGERY DATE: 05/14/2014
AGE: 45
DR: Timothy G. Hiesterman, DO

EXHIBIT D

St. Joseph's Hospital
45 W 10th Street
St Paul, MN 55102-1062

TAYLOR,ZACHARY T
Sex: M
Enc.Date12/30/14

Admission Information

Unit/Bed:	/	**Service:**	
Admitting provider:		**Phone:**	
Attending provider:	Lawrence Tee Donovan, DO	**Phone:**	651-968-5479
PCP:	Stephen J. Craane, MD	**Phone:**	651-779-1337
Admission dx:		**Patient class:**	Outpatient
Admission type:	EL		

Consults signed by Lawrence Tee Donovan, DO at 1/8/2015 8:11 AM

Author: Lawrence Tee Donovan, DO Service: (none) Author Type: Physician
Filed: 1/8/2015 8:11 AM Note Time: 12/30/2014 7:57 AM Status: Signed
Editor: Lawrence Tee Donovan, DO (Physician)

DATE OF SERVICE: 12/30/2014

This is a 46-year-old male who is being evaluated in regards to his left wrist at the request of Dr. Quiram.

The patient relates that he sustained an injury. He was tackled and sustained a fracture of his distal radius. Underwent an open reduction and internal fixation back in 05/2014, presumably in St. Cloud, Minnesota. He was placed into a short arm splint a week or so later and did home exercise therapy. He has been at Oak Park Detention Facility since that time. He presents with complaints of pain and stiffness as well as numbness and tingling. He relates the pain is rather constant achiness, worse with activity such as typing or writing or doing any type of grasping type activity. Does not describe any catching or locking of the fingers.

The numbness and tingling seems to be relatively constant in nature. He does not awaken with any numbness or tingling.

PAST MEDICAL HISTORY: Unremarkable. Denies any diabetes or thyroid dysfunction. Denies any lower extremity paresthesias. There is no family history of carpal tunnel syndrome.

St. Joseph's Hospital
45 W 10th Street
St Paul, MN 55102-1062

TAYLOR,ZACHARY T
, Sex: M
Enc.Date12/30/14

Consults signed by Lawrence Tee Donovan, DO at 1/8/2015 8:11 AM (continued)

PHYSICAL EXAMINATION: A well-developed, well-nourished male, alert and cooperative,
in no apparent distress while at rest. He ambulates with a relatively normal gait.
RIGHT WRIST: Reveals no swelling or deformity. He has normal range of motion. He
does have a Dupuytren's nodule on the palm of the hand which is nontender. There is
no contracture. He is grossly neurovascularly intact.
LEFT WRIST: Reveals a well-healed volar radial surgical scar. There is no swelling
or effusion of the wrist. His range of motion is approximately 30 degrees of
flexion and extension each. He has painful limited range of motion in radioulnar
deviation planes. He has limited pronation and supination.

Motor examination shows normal strength of the left hand. There is no intrinsic or
thenar atrophy.

Two-point discrimination is intact with the exception of the thumb and index finger.
Tinel's over the carpal tunnel is positive. Tinel's negative. Phalen's is not
able to be performed due to limited wrist motion.

Vascular examination reveals normal skin color, temperature, capillary refill and
radial pulse bilaterally.

X-rays not available for review; however, there is an x-ray report dated 09/05/2014.
A comparison x-ray of the left wrist, 3 views, as compared to 08/04/2014. There is
no definite radiographic evidence of acute fracture or dislocation, no change from
prior exam. Evidence of open reduction internal fixation of distal radius fracture.
No widening of the scapholunate gap.

IMPRESSION:
1. Status post open reduction internal fixation distal left radius.
2. Post-fracture stiffness, left wrist.
3. Numbness left hand. Question carpal tunnel syndrome.

St. Joseph's Hospital
45 W 10th Street
St Paul, MN 55102-1062

TAYLOR,ZACHARY T
, Sex: M
Enc.Date12/30/14

Consults signed by Lawrence Tee Donovan, DO at 1/8/2015 8:11 AM (continued)

4. Bilateral hand Dupuytren disease without contracture.

PLAN: I have outlined the options of treatment to the patient. At the present time
he does not fill the numbness and tingling is severe enough to warrant any surgery;
therefore, recommend observation. If the numbness and become more symptomatic, I
would recommend obtaining an EMG and nerve conduction study. If he has wrist pain
persists, I would recommend he be reevaluated in the future. Should bring his
x-rays with him. It those are unavailable then I would obtain a new set of x-rays
to determine whether or not any surgery would be necessary.

LAWRENCE T DONOVAN, DO
ta
D 12/30/2014 07:57:38
T 12/30/2014 08:31:46
R 12/30/2014 08:31:46
10304844

cc: STEPHEN CRAANE MD
LAWRENCE DONOVAN DO

St. Joseph's Hospital
45 W 10th Street
St Paul, MN 55102-1062

TAYLOR,ZACHARY T
, Sex: M
Enc.Date02/17/15

Admission Information

Unit/Bed:	/	**Service:**	
Admitting provider:		**Phone:**	
Attending provider:	Lawrence Tee Donovan, DO	**Phone:**	651-968-5479
PCP:	William A Brombach, MD	**Phone:**	651-232-4800
Admission dx:		**Patient class:**	Outpatient
Admission type:	EL		

Consults signed by Lawrence Tee Donovan, DO at 2/17/2015 3:41 PM

Author: Lawrence Tee Donovan, DO Service: (none) Author Type: Physician
Filed: 2/17/2015 3:41 PM Note Time: 2/17/2015 8:30 AM Status: Signed
Editor: Lawrence Tee Donovan, DO (Physician)

DATE OF SERVICE: 02/17/2015

This is a 46-year-old male who is being evaluated in regards to his left hand. He apparently got his hand caught between a book cart in the door at the prison. Date of injury is on or about 01/03/2015. He was evaluated at HealthEast Emergency Room and was noted to have a fracture of the small finger metacarpal.

He has persistent pain over the small finger metacarpal shaft which is gradually getting better. He does complain of pain with grasping activities.

He also complains of continued pain in his left wrist following open reduction internal fixation that was performed in St. Cloud.

There has not been any change in his past medical history.

PHYSICAL EXAMINATION: A well-developed, well-nourished white male, alert and cooperative, no apparent distress while at rest. He is alert and oriented x3. He ambulates with a normal gait.

Examination of the left wrist and hand reveals a well-healed surgical scar over the volar radial side of the hand which is well-healed. His range of motion is approximately 30 to 40 degrees of flexion and extension each with mild pain dorsally.

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TAYLOR,ZACHARY T
], Sex: M
Enc.Date02/17/15

Consults signed by Lawrence Tee Donovan, DO at 2/17/2015 3:41 PM (continued)

He has mild swelling over the small finger metacarpal shafts. He has mild tenderness present. There is no rotational deformity of the finger. He has near full flexion of the fingers. The joints are stable. Skin is benign. He is neurovascularly intact.

Review of a 3-view x-ray of the hand demonstrates a mid shaft fracture of the small finger metacarpal. He has slight apex dorsal angulation present. There is still somewhat of a radiolucency present.

IMPRESSION: Healing fracture, left small finger metacarpal shaft.

PLAN: At the present time, I would recommend observation. He can do activity as tolerated. He will follow up if he remains painful.

ADDENDUM: He has an internal fixation plate present in the distal radius. He does not appear to have any implant failure. The lateral x-ray is suboptimal to evaluate subchondral placement of the screws.

LAWRENCE T DONOVAN, DO
sa
D 02/17/2015 08:30:05
T 02/17/2015 09:23:47
R 02/17/2015 09:23:47
10313697

cc: WILLIAM BROMBACH MD
LAWRENCE DONOVAN DO
SUMMIT ORTHO WOODBURY CLINIC

St. Joseph's Hospital
45 W 10th Street
St Paul MN 55102-1062

TAYLOR,ZACHARY T
, Sex: M
Enc.Date06/30/15

Admission Information

Unit/Bed:	/	**Service:**	
Admitting provider:		**Phone:**	
Attending provider:	Lawrence Tee Donovan, DO	**Phone:**	651-968-5479
PCP:	William A Brombach, MD	**Phone:**	651-232-4800
Admission dx:		**Patient class:**	Outpatient
Admission type:	EL		

Consults signed by Lawrence Tee Donovan, DO at 7/7/2015 2:47 PM

Author: **Lawrence Tee Donovan, DO** Service: (none) Author Type: Physician
Filed: 7/7/2015 2:47 PM Note Time: 6/30/2015 8:32 AM Status: Signed
Editor: Lawrence Tee Donovan, DO (Physician)

DATE OF SERVICE: 06/30/2015

This patient is being followed up in regard to his left wrist. The patient complains of stiffness, pain, and intermittent numbness and tingling.

His main complaint is pain over the volar and to a lesser degree dorsal side of the wrist. The pain is worse with activity. He states when he tries to write for more than 3 to 4 minutes he has discomfort. He describes intermittent numbness of the small and ring finger which occurs approximately 2 times per week. This seems to be unrelated to any particular activity. He denies any nocturnal paresthesia, neck pain, or specific weakness.

He had discomfort which is unrelieved with the use of prednisone. He does not describe any swelling, catching, or locking.

There has not been any change in his past medical history other than apparently sustaining a fracture of the left small finger metacarpal shaft which was treated nonoperatively.

Physical examination shows a well-developed, well-nourished white male alert and cooperative, no apparent distress while at rest, alert and oriented times 3, ambulation with normal gait.

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45 W 10th Street
St Paul MN 55102-1062

TAYLOR,ZACHARY T
, Sex: M
Enc.Date06/30/15

Consults signed by Lawrence Tee Donovan, DO at 7/7/2015 2:47 PM (continued)

Examination of the left wrist and hand, his incision is well healed. There is no sign of infection. There is no definite effusion or swelling. There is no swelling of the extensor tendons.

His wrist range of motion: Flexion is 30 degrees, extension 30 degrees. He does complain of some dorsal and volar pain with flexion and extension of the wrist.

His extensor tendons are intact to include the thumb extensor pollicis longus. He has questionable weakness of the extensor pollicis longus, extensor digitorum comminus, and extensor wrist function is 5/5. Abductor pollicis brevis, first dorsal interosseous and abductor digiti minimi and intact. There is no thenar intrinsic atrophy. Sensory examination is grossly intact. Tinels is negative at the cubital tunnel, carpal tunnel and Guyon's canal.

Vascular examination reveals normal skin color, temperature, and capillary refill.

He does complain of some pain along the volar aspect of the wrist over the area of the plate. He has pain over the dorsal aspect of the distal radius as well.

Review of a PA, lateral and oblique x-ray of the wrist dated 02/09/2015, he has a healing fracture of the small finger metacarpal shaft which appears to be in satisfactory alignment. He has abundant callus formation. He appears to have a Synthes type distal radius plate in place. The PA x-ray demonstrates there is possibly a slight ulna positive variant. The fracture itself appears to be healed. The oblique x-ray demonstrates some mild cystic changes in the radial styloid. The lateral x-ray is suboptimal for visualizing the placement of the screws in

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TAYLOR,ZACHARY T
, Sex: M
Enc.Date06/30/15

Consults signed by Lawrence Tee Donovan, DO at 7/7/2015 2:47 PM (continued)

subchondral bone at the articular surface level. A lateral hand x-ray dated
02/09/2015, there is a question of a slight radial lucency around the screws in the
subchondral surface of the articular surface of the distal radius.

IMPRESSION:
1. Status post open reduction internal fixation of the distal left radius with
postoperative stiffness.
2. Healed fracture left small finger metacarpal shaft.

PLAN: I have outlined the options of treatment to the patient. I have indicated to
him that some of the pain he is experiencing is related to the internal fixation
device. I have outlined the options of treatment. I indicated to him that he could
consider having a plate removal.

I have counseled the patient as to the risks of surgery to include but not necessary
limited to allergic reaction, bleeding, infection, technical problems, nerve, tendon
or artery damage, failure of surgery, risks of anesthesia and possibility of death.

CC: Summit Ortho Hand Center

LAWRENCE T DONOVAN, DO
ca
D 06/30/2015 08:32:08
T 06/30/2015 09:01:06
R 06/30/2015 09:01:06
10340604

cc: WILLIAM BROMBACH MD
LAWRENCE DONOVAN DO
Summit Ortho Hand Clinic

EXHIBIT E

Op Note - Anesthesia/Surgical Notes

Op Note by Lawrence Tee Donovan, DO at 8/18/2015 10:27 AM
Author: Lawrence Tee Donovan, DO | Specialty: | Author Type: Physician
Note Time: 8/18/2015 10:27 AM | Filed: 8/18/2015 10:31 AM | Status: Signed
Editor: Lawrence Tee Donovan, DO (Physician)

Preoperative diagnosis:
Status post open reduction internal fixation distal left radius fracture with retained painful hardware

Postoperative diagnosis:
Same.

Procedure:
Complex hardware removal left wrist

Surgeon:
LT Donovan D.O.

Assistant:
Jessica Kainz, P.A.-C
PA-C assist was required for patient positioning, soft tissue retraction, instrumentation assist, and patient safety.

Anesthesia:
Regional/MAC

Specimens:
Distal radius plate and screws

Estimated blood loss:
None.

Complications:
None.

Condition:
Stable to the recovery room.

Implants:
None

Findings:
The fracture appeared to be healed. No evidence of any hardware failure. There was noted be rather significant fibrosis and the flexor carpi radialis tendon and the plate itself.

Postop plan:
Patient can remove his dressing approximately 2 day start on gentle range of motion. He'll follow up in approximately 2-4 weeks. No x-rays necessary.

Procedure note:
After adequate regional block anesthetic the left upper extremity was then prepped and draped in usual sterile fashion. The arm was exsanguinated tourniquet inflated to 250 mmHg a proximal arm. Utilizing the previous

Op Note - Anesthesia/Surgical Notes (continued)

Op Note by Lawrence Tee Donovan, DO at 8/18/2015 10:27 AM (continued)

scar and incision was made over the volar radial aspect of the forearm directly over the flex carpi radialis tendon. Under loupe magnification sharp dissection performed down to subcutaneous tissue. The flexor carpal radialis tendon was then mobilized. The interval between the tendon and artery was then entered. There is noted fairly significant amount of fibrosis at this level. A portion of the pronator quadratus was covering the plate. This was reflected.

The plate and screws and removed without difficulty. Clinically, the fracture appeared to be stable. Intraoperative passive range of motion flexion of 40° extension 45°. Intraoperative x-rays were obtained. Fracture appeared to be healed.

The wound was then irrigated and closed. Sterile compression dressing applied to the upper extremity. The tourniquet was then deflated. There is excellent capillary refill noted in all digits.

Electronically Signed by Lawrence Tee Donovan, DO on 8/18/2015 10:31 AM

All Meds and Administrations

ceFAZolin 2 g in 100 mL in D5W (ANCEF) [22058608] — Status: Completed (Past End Date/Time)

Ordering Provider: Lawrence Tee Donovan, DO
Ordered On: 08/17/15 1117
Dose (Remaining/Total): 2 g (0/1)
Route: Intravenous
Admin Instructions:

Starts/Ends: 08/18/15 0700 - 08/18/15 0930
Frequency: 30 min pre-op
Rate/Duration: 200 mL/hr / 30 Minutes
Comments: Patient weight not documented
Weight >/= 120 kg dose is 3 gram
Weight < 120 kg dose is 2 gram

Administration	Status	Dose	Route	Site	Given By
08/18/15 0930	Given	2 g	Intravenous		Justine Marie Lindgren, CRNA

lactated ringers [46798203] — Status: Discontinued (Past End Date/Time), Reason: Patient Discharge

Ordering Provider: Erik S Eckman, MD
Ordered On: 08/18/15 0828
Dose (Remaining/Total): 100 mL/hr (-/-)
Route: Intravenous
Admin Instructions: Omit if IV fluids already running - continue existing fluids.

Starts/Ends: 08/18/15 0827 - 08/18/15 1405
Frequency: Continuous PRN
Rate/Duration: 100 mL/hr / -
Comments:

Administration	Status	Dose	Route	Site	Given By
08/18/15 1137	Stopped Rate: 0 mL/hr	0 mL/hr	Intravenous		Shannon Havlicek, RN
08/18/15 1024	Anesthesia Volume Adjustment		Intravenous		Justine Marie Lindgren, CRNA
08/18/15 1011	New Bag		Intravenous		Justine Marie Lindgren, CRNA
08/18/15 0919	New Bag		Intravenous		Justine Marie Lindgren, CRNA
08/18/15 0835	New Bag Rate: 100 mL/hr	100 mL/hr	Intravenous		Shannon Havlicek, RN

EXHIBIT F

STEARNS COUNTY JAIL
TAYLOR, ZACHARY
REPORT DATE : 04/14

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
RTANE 5MG TAB TRIHEXYPHENIDYL 5 MG TABL 06748469 TAKE 1 TABLET BY MOUTH ONCE DAILY	AM: Discontinued
AMITRIPTYLINE 100MG TAB 06748468 TAKE 1 TABLET BY MOUTH AT BEDTIME 3-27-14	HS: [illegible]
FIXODENT CREAM 06748445 USE ON DENTURES ONCE DAILY AS needed n amt in med cup (EB) 3-22-14	Am: [illegible] non PM HS
rtane 5mg tab PO 1xDAily 3-27-14	Am: Discontinued HS
Xycodone-Acetamin. 10-325mg tab PO 1 Daily PRN T.I Gone 3/21/14	Am: [illegible] non HS
(IBU 800 mg 1 tab PO as needed x daily (x 7 days) 4-4-14	Am: [illegible] PM HS: Discontinued
mitriptyline 25mg 1 tab PO 1xDaily 4-11-14 if w/other order to = 125mg)	HS: [illegible]

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

ARTING FOR 04/01/14 THROUGH 04/30/14 PAGE 1

sician LANGENFELD, MARTY — Telephone No. 763-428-3409 — Medical Record No

Physician — Alt. Telephone

rgies SUCCINYLCHOLINE — Rehabilitative Potential

MAR KEY
R = Refusal
C = Court
O = Med on Order
X = No Show
W = Work/STS/Furlough/Treatment/Writ

gnosis

ficaid Number | Medicare Number | Approved By Doctor: | By: | Title: | Date:

ESIDENT TAYLOR, ZACHARY | D.O.B. | Sex M | Room STEARNS JL | Patient Code TAYLZ | Admission Date 02/16/14

1-0014

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
Oxycodone-Acetaminophen 10-325 mg tab PO 3x daily PRN DK Luthen gave 3/21/14	am, noon, HS
fixodent (stock) small amt. in med cup 1x daily PRN 3-22-14	Am, Noon, pm, HS
Amitriptyline 100mg 1 tab PO 1x daily 3-27-14	HS
Artane 5mg 1 tab PO 2 x daily 3-27-14	Am, HS

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

ARTING FOR March 2014 THROUGH

ysician M. Langenfeld Telephone No. Medical Record No.

Physician Alt. Telephone

ergies Rehabilitative Potential

gnosis

caid Number | Medicare Number | Approved By Doctor: By: Title: Date:

ESIDENT Taylor, Zach Sex M Room # Patient Code Admission Date

1-0015